



STAT!

REQUEST FOR RELEASE OF INFORMATION

Hospital/Other:

PATIENTS NAME:

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

DATE(S) OF SERVICE:

REQUESTOR NAME Dr.

Please fax all intake/discharge summaries, lab reports, x-ray reports, operative reports, pathology notes, progress notes, consultation notes to

214-942-4313

Patients Signature: _____ Date: _____

Expires: 2 Years